Pedic Society Items

Vol. I. September, 1908 No. 6

Published by the PEDIC SOCIETY of the State of New York, Grand Opera House Hall, 23rd Street and 8th Avenue, New York City.

ELLIOTT W. JOHNSON, President, Astor House, Broadway and Vesey St., N. Y. C.

MAX NACHBAR, Secretary, 344 Manhattan Ave., N. Y. C.

HARRY H. MOORE, Treasurer, 874 Broadway, N. Y. C.

ADVERTISING RATES, $1.00 AN INCH FOR EACH INSERTION

MEETINGS OF THE PEDIC SOCIETY

The April, May and June meetings of the Pedic Society witnessed a large outpouring of members, who evinced a great interest in the proceedings and were highly pleased with the lectures and informal discussions which were held.

The Society in June passed a resolution to adjourn for the summer months, and, therefore, the next meeting will not be held until the second Tuesday of October.

PERSONAL

President Elliott W. Johnson of the Pedic Society is spending his vacation at the country place of Dr. H. D. Johnson, at Sag Harbor, on Peconic Bay, L. I. Both of the doctors report the fishing excellent and the mosquitoes healthy.

Chairman George Erff, of the Board of Examiners, is spending his vacation whizzing around the country in his 40-horsepower Panhard, with the usual accompaniment of bursting tires and incorrigible spark plugs, in the repair of which Mr. Erff has become quite an expert.

Mrs. Clara Judelson is summering, as usual, at her cottage at Long Branch, and is often visited by Mrs. Brotman, the former secretary of the Pedic Society.

Treasurer George I. Mardin, of the Board of Examiners, is catching the speckled beauties at his camp at Wolfboro, N. H., which is beautifuly situated in the famous White Hills. A number of friends have visited him from time to time and report him in unusually good health. Secretary Max Nachbar and his wife have spent part of their vacation with Mr. Mardin.

R. P. Jantzen, secretary of the Board of Examiners, is whiling away the hot season at his summer home, on the banks of the Hudson.

Chairman Dahlke of the Advisory Board has just returned from an extended trip West. On his way back to New York he stopped off at Buffalo and was cordially entertained by Oscar M. Goldberg, one of the members of the Executive Board. Mr. Goldberg's many friends in the metropolis will be glad to learn that he intends to visit New York at any early date. While Mr. Dahlke was marvelling at the scenery of Niagara Falls he met Mr. Vincent DeSio, of Stapleton, S. I., and the duo spent a very enjoyable and instructive time investigating the many natural wonders at the Falls.

SECRETARY MAX NACHBAR HAS REMOVED TO 344 MANHATTAN AVENUE, N. Y., WHERE ALL MAIL SHOULD BE ADDRESSED.

MAY EXAMINATION

The examination held on May 26th, 1908, by the Board of Examiners produced another large class, and the proficiency of the students was shown to a greater extent than ever before. Those who passed the examination are as follows:

Edwin K. Burnett, New York.
Victor Burr, New York.
William E. Bland, Binghamton.
Joseph F. Heimbach, Brooklyn
Constantine A. Bowling, New York
Bernard Izan, New York.
Harriet Locke Curtis, Auburn.
Isabel G. Cody, Rochester
Walter J. Harrington, Schenectady.
Henry C. Karpen, Brooklyn.
John G. Seche, New York.
John G. Erixon, Jericho, Nassau Co.
Sigmund Lederer, New York.
Benjamin Hacker, New York.
James W. Harty, New York.
William J. Williams, New York.
Michael J. Daly, New York.
Leo Feder, Brooklyn.
Jacob Lamb, Rockaway Beach.
Frank E. Humphreys, New York.
Alfred A. Robie, Newburgh.
Charles L. Kahler, Mt. Vernon.
John P. Paulin, Buffalo.

ANOTHER CONVICTION

On May 27, 1908, at the Court of Special Sessions, First Division, Manhattan, New York City, one Philip Kronengold, of the Borough of Manhattan, was fined $50 for illegally practising chiropody.

The work of sifting out and prosecuting offenders is being pursued with caution and certainty, and the Society is doing all in its power to see that the laws are complied with.

THE APRIL, 1908, MEETING OF THE PEDIC SOCIETY

This meeting will go down in history as a red letter one. Upon invitation of the Board of Examiners a lecture upon the subject, "Diabetes as Related to Chiropody," was delivered by Dr. Harry Dash Johnson, and was followed by a discussion upon points brought forth, which was indulged in by Dr. Francis E. Knowles, Dr. Victor Fredrickson and Dr. Leonard W. Ely, all these medical gentlemen having during their practice frequently had occasion to observe the effects of the disease upon patients. The Society issued numerous invitations to non-members to attend the meeting and take advantage of the good to be derived therefrom. A large number of chiropodists, both members and non-members of the Society, were present and were unanimous in the decision that the lecture and discussions were sources of great good to them in their practice.

Dr. Johnson's lecture and Dr. Knowles' discussion have been reduced to writing and are printed in this issue. Dr. Fredrickson's discussion and Dr. Ely's discussion are expected to be printed in a subsequent issue.

What a Child Thinks of Sterilization

The following was received by one of the members from a little girl nine years of age who has just recovered from a severe operation. For obvious reasons names, etc., are omitted.

April 22, 1908.

Dear Mrs. ————

I received your letter and was glad to hear from you. I am much better and will be home in a week or so.

My doctor brought down some books and I read to a little blind girl who is here. Her name is —— ——. She is getting so she can see nicely, but can't read or write. Her parents are very poor and she is the oldest of four children, and she is only eleven.

THERE WAS AN ABSCESS FORMED IN ONE OF THE STITCHES AND SO I HAD MORE THAN MY SHARE OF THE PAIN. IT WAS CAUSED BY NOT STERILIZING ENOUGH, SO YOU SEE YOU CAN'T BE TOO CAREFUL.

Yes, I am minding the doctors and nurses so as to get well for I hate to miss my school.

I send my love to all and remain,

Your loving friend,

HATTIE L. ————.

Diabetes Melitus and Its Complications as Related to Chiropody

LECTURE DELIVERED BEFORE THE PEDIC SOCIETY BY HARRY DASH JOHNSON, M. D.

It has long been recognized that operations, even for the minor affections, on subjects suffering from Diabetes Melitus are followed frequently by fatal results. Before considering the cause of these conditions let us study the disease itself.

Diabetes Melitus is a nutritional disorder attended by an abnormal amount of sugar in the blood. The disease may appear suddenly or its onset may be gradual, the patient suffering for some time before the true nature of the disease is discovered.

In the acute cases the patients assert positively that the quantity of urine voided became suddenly great, that they were obliged to arise at night to pass water—suffering from great thirst and hunger, and despite the large quantity of food taken they persistently lost flesh and strength. To these symptoms may be added insomnia, nervous irritability and general pruritis. As a rule this class of cases give a family history of Diabetes or some constitutional disease and complain of some great psychic disturbance or bodily injury.

In the chronic form the disease appears insidiously, frequently being mistaken for overwork, neurasthenia or nervous dyspepsia, etc. Prominent among the first symptoms are headache, indigestion, lack of application and general malaise. This is followed by an increase in quantity of urine and frequency of micturition, abnormal appetite and progressive loss of flesh and strength. The skin is hard and dry, frequently the patient complains of general itching or pruritis. The countenance is drawn and wan. The blood and all the secretions are found to contain an excess of sugar. The continued presence of sugar in the urine is the diagnostic sign of this disease—and in all cases of which there is a question of Diabetes Melitus the chiropodist should have repeated chemical examinations made of the urine by some competent pathologist or chemist.

As has already been said, Diabetics show an extraordinary tendency to complications, particularly to infective processes. There has been much discussion as to the cause of these complications. We notice that sometimes they have the character of inflammation and at others that of simple disturbance of nutrition, of necrosis or of degeneration. Some attribute it to the bad general nutritive condition, which reduces the power of resistance of every portion of the body. Other authors believe that the high percentage of sugar in the circulating fluids exerts a direct injurious influence upon the organs of the body, whether by withdrawing water from the tissues or by impregnating them with a concentrated saccharin solution, the sugar acting as a poison to the tissues. The high percentage of sugar in the fluids is regarded as injurious from another point of view also. Grape sugar, as is well known, favors the growth of a vast number of micro-organisms; the tendency of the diabetic to certain infectious diseases might therefore be due to the presence of a very favorable saccharin soil in the diabetic organ.

A third view as to the etiology of the complications of diabetes is that in addition to the undoubted evil results of lowered nutrition, there are certain toxic substances present which are prejudicial to the integrity of the organs. Their action is alleged especially in certain degenerations and functional disturbances. These are all, however, theories, and we will do well to keep always in mind the fact that every diabetic has less power of resistance against noxious influences than the healthy individual. This brings us to the consideration of complications which the chiropodist will most frequently see.

Let us first consider pruritis, or itching. This may be general or involve cer-

tain parts of the body, the feet being frequently alone involved. It may be constant or intermittent, occurring most frequently when the subject is overheated and the parts are bathed in saccharin perspiration. Numerous lotions and ointments are advised for this condition. If the skin is hard and scaly a two per cent. carbolic ointment is a good local measure, but diet and systemic treatment by the patient's physician will accomplish the best results. Paresthesia, localized anesthesia and hyperasthesia are frequently present when the disease attacks the nervous system. Cramps in the calves of the legs and neuralgia also frequently appear as complications. Paralysis of the lower extremities, usually bi-lateral, has also been noticed. Localized atrophy of the skin and glossy skin may appear, the toe nails may become thin or a general shedding of the nails may occur, obstinate eczema and onychia are often found. Spontaneous gangrene of the skin due to trophoneurosis may occur independent of arteriosclerosis. For these affections a repression of the Glycosuria by the institution of a suitable diet under the direction of the patient's physician will be found at times beneficial. Arteriosclerosis independent of other factors is frequently the cause of gangrene.

Boils or furunculosis is a common condition and occurs most frequently where personal cleanliness is neglected. This is also the case with carbuncles. Ulcers, large or small, may occur either from atrophy of the skin, spontaneous gangrene, or from trauma. They frequently are produced from breaking the skin while scratching to relieve the pruritis. Ulcers appear in what is commonly called "The Diabetic Root." Diabetic ulcers frequently present foul discharging surfaces with unhealty granulation tissues, the surrounding part is swollen, œdemitous and bluish in color, the skin being dry, hard and scaly. It is not wise to try and form a scab over these ulcers, but to substitute healthy granulations for the unhealthy ones by using stimulating and antiseptic washes and dressings. Do not try to dry up the discharge with a powder, for anything that tends to scab over the surface will prevent the proper discharge of pus, whose absorption will produce toxic symptoms. In treating these ulcers the most scrupulous surgical cleanliness must be observed and persisted in. All injuries or traumatisms are to be carefully watched, for any inflammation of the skin will surely be followed by gangrene unless given most careful care. All abrasions, scratches or where the skin is slightly worn off must receive thorough antiseptic washing, and proper dressings must be applied to prevent micro-organisms gaining access to the absorbing tissues. It is true that all unnecessary surgical procedures should be avoided in cases suffering from diabetes, but the necessary ones should not be shirked. Many chiropodists feel that patients suffering from diabetes should not have their feet treated. This is not so, as there is no class of cases which should pay more attention to affections of the feet than diabetics, and no one is better qualified to do this than the chiropodist. It is a necessary operation either for an ingrown nail or corn, and with a proper understanding of the case the risk will be less than if the affection is not treated or the patient is allowed to treat himself.

Let us suppose a diabetic subject presents himself to us suffering from ingrown nails and corns; we know that he presents a fertile soil for the growth and propagation of bacteria, the oposonic power of his blood is diminished, his fighting army is at a low standard, nature does not supply the proper food for the blood and the necessary antitoxines or alixenes that should neutralize the toxines, are not produced. Thus warned, it is necessary for us to maintain the strictest watch on our technique. After thoroughly cleansing our hands, the part to be operated—say, the nail—is to be thoroughly washed with warm water and tincture of green soap, scrubbing the while gently with sterilized absorbent

cotton, being particular to cleanse the nail groove and remove all foreign substance from about the nail. Rinse thoroughly and apply alcohol, then immerse in a one in two thousand solution of bichloride of mercury for at least three minutes. The operator again attends to the toilet of his hands and immerses them in a bichloride solution. The instruments having previously been sterilized by boiling or immersed in pure carbolic acid for five minutes and then in absolute alcohol. We are now ready to remove the offending portion of the nail. This is done in the usual way, any superfluous granulations are destroyed with a proper caustic. The wound is then dressed with sterilized, or, preferably, aseptic gauze, so that no micro-organisms can gain access to the wound through the dressing. Do not let the patient wet or remove the dressing, but have him return daily and after thoroughly cleansing the hands redress in the same way until entirely healed. As for the corns, maintain the same care in cleansing the hands and part to be operated; sterilize the instruments and remove in the usual way, being careful to remove only a small portion, not cutting close enough to expose an absorbing surface or cause irritation. As a dressing, paint the clavus with iodine and seal same with a solution of aristol and collodion ten per cent. Then apply a ring shield or whatever dressing is indicated. The patient should be instructed to appear at least every two weeks for treatment. In this way a simple operation each time will relieve him and minimize the chance of inflammation or infection. For the cases in which infection is present or where extensive inflammation exists I would advise your calling in a physician to treat the case with you.

It is well known that any injury or inflammation of the skin in diabetics is likely to be followed by gangrene; therefore, all cases suffering from this disease and presenting themselves to the chiropodist for treatment should be warned of this complication and instructed how best to avoid it.

In closing let me remind you that not alone are diabetics particularly susceptible to infective processes, but that there are many acute and chronic diseases which are characterized by lessened resistance to infection. Prominent among them are acute and chronic Bright's disease, arteriosclerosis, cardiac disease, alcoholism, syphilis, rickets, scurvy, leucocythemia and Hodgkin's disease.

Discussion of the Above by Francis E. Knowles, M. D.

Mr. President, Ladies and Gentlemen:

Dr. Johnson should be congratulated on his paper. He has gone over the subject so very thoroughly that it will be hard either to add to or criticise it.

One thing, however, I would like to have heard him go into a little thoroughly—that is, the etiology or causative factors of diabetes, because the recent scientific researches in our own country make it more than ordinarily interesting. Until the year 1900 the cause or causes of diabetes was one of the mysteries of the medical profession. In that year Dr. Opie, of Baltimore, published a pathological study on interstitial pancreatitis, in which he for the first time demonstrated a connection between disease of the islands of Langerhan and diabetes. These islands of Langerhan are groups or columns of cells found in the pancreas, but have no connection with the ducts of the gland, showing that their function is other than to aid in the production of pancreatic juice. They are, however, intimately surrounded with the ducts by a rich network of blood vessels, therefore occurring as ductless glands, and being surrounded by a rich capillary network, it is extremely probable that these islands secrete some glycolytic ferment which enters the blood and has the property of changing the sugars so that they may be absorbed and assimilated by the system. When this does not take place the sugars become floating derelicts and poisons in the system and bring about that long train of symptoms and

conditions which Dr. Johnson has so admirably described to you to-night. As the doctor has told you, diabetics are very easily infected. The sugars in the blood irritate the sensory nerves in the skin, causing a great deal of itching. Patients in relieving this condition very often break the skin, forming foci for the admission of infectious organisms, which may cause boils, abscesses or carbuncles. Deep inflammations of the fingers or toes may occur, which result in the loss of the nails. Herpes Zoster, or shingles, and perforating ulcer, which so often occur in the feet, are the result or expression of an inflamed nerve—diabetic neuritis. Spontaneous diabetic gangrene is mostly found in the lower extremities, affecting usually the toes, sometimes extending backward until it involves the whole foot; occasionally it will commence in the heel. It is always an expression of impaired blood supply to the part; the arteries are nearly always hardened, and the lumen of the vessel sometimes found entirely obliterated. The nails in some cases have been found to be very slow of growth. In advanced cases œdema, or swelling of the feet, even without evident venal or cardiac affections, is not uncommon. But one of the most important things for you to remember in treating these cases, and what Dr. Johnon tried most forcibly to impress upon your minds, was their peculiar susceptibility to infections, and every aseptic and antiseptic precaution should be taken. However, I feel that a certain amount of care should be used regarding strong antiseptics, and I believe it a good precaution to wash a wound with sterile water after their use in cases that are in an advanced stage of the disease, when the vitality of the tissues is low; in such cases, a too strong antiseptic, if allowed to stay in contact with the tissues too long, might cause an ulcerative or sloughing condition.

Advertisers report good results from ads. in the "Items."

A Case of Intermittent Limping with Suggestions as to Treatment

LEONARD W. ELY, M. D., NEW YORK.

Under this and other names[1] various authors have described a disease rather rare in this country, but occurring much more frequently in Russia. It consists of an obliterating endarteritis, and often ends in gangrene. The two characteristics are: First, the absence of pulsation in the arteries of the affected limb; and, second, a peculiar lameness accompanied by pain and by a sense of constriction in the calves. This pain comes on when the patient has walked a short distance and subsides when he comes to a stop.

The case here reported is interesting for several reasons, principally, however, as showing the curative powers of rest. The patient was seen while under treatment, without the knowledge of his regular attendant, by one of the most eminent consultants in New York, and was told that he would never walk on his foot again. He had already lost one foot, and therefore was willing to carry out the long and tedious treatment prescribed for him. Lovett, in his excellent article on this disease,[2] strongly advised rest as the one hope for recovery.

No examination was made of the foot that had been amputated, and little that is interesting can be learned of the patient's previous history from his former medical advisers, except the rather suggestive statement of one of them that "A. M. has lived a pretty swift life and has been a puzzle to all the doctors. The amount of albumin in his urine at times is shocking."

Patient.—A. M., aged 39 years, manager, married, and having two children,

1. Intermittent claudication: dysbasia angiosclerotica, angina cruris; myasthenia paroxysmalis angiosclerotica, etc. The term intermittent claudication is misleading. The closure of the arteries is permanent, though the symptoms may intermit. Herein this disease appears to differ from Raynaud's disease and from erythromelalgia. Again, Raynaud's disease is found most often in the upper extremities.

2. Jour. Am. Orthop. Assn., 1906.

was first seen Aug. 6, 1906, complaining of intermittent limping.

History.—In 1897 he was examined for life insurance and albumin was found in the urine. In 1898, patient had what appeared to be rheumatism in the heel, followed by a similar condition in the forearms, both of which were swollen, red and sore. Symptoms yielded to anti-rheumatic remedies. He denies syphilis.

In 1899 a peculiar form of limping appeared, a sense of constriction and pain in both calves appearing when the patient had walked a short distance, and disappearing when he rested. This was followed by swelling and redness along the right leg and foot. The patient went to bed for six weeks, took large doses of bicarbonate of soda, lemon juice and iron, and gradually recovered. There was a slight recurrence of these symptoms in 1900 and 1901, in both legs, but not severe enough to keep the patient from his business.

In June, 1902, an ulcer appeared under a corn on the fourth toe of the right foot, and refused to heal. One month later this ulcer was curetted. Then, on account of failure to heal, the toe was amputated. After this, for the same reason, there followed four more operations, the last in July, 1903—evidently, first, an amputation of the metatarsal; second, an amputation from the big toe across the foot, removing the four outer toes: third, skin grafting; fourth, an amputation of the lower third of leg. The wound then healed promptly.

In 1904 and 1905 there was a slight recurrence of the trouble in the left leg, which seemed to be held in check by anti-rheumatic remedies. There has been no trouble in the right lower extremity since the amputation. Patient wears an artificial foot.

In May, 1906, the patient began to experience pain in the left foot and leg. The symptoms increased and interfered with the carrying on of his business.

Examination and Treatment.—Aug. 6, 1906, there was a slight redness and thickening about the internal malleolus and inner side of foot, which was sensitive to pressure. The diagnosis made was lymphangitis. Treatment consisted of wet dressings of aluminum acetate.

The symptoms grew better, then recurred. Mercurial ointment was applied, and although the patient presented no signs of syphilis, and said that he had undergone a rather thorough anti-syphilitic treatment some years before, he was put on iodid of potassium, and later had five injections of salicylate of mercury. Stockinette bandages were applied to the leg. On one or two occasions the patient kept his bed for a week or two and then seemed to become markedly better.

Following the inflammatory swelling about the ankle came a similar condition along the inner border of the gastrocnemius, a painful, thickened, indurated cord—evidently a phlebitis. Later, this phlebitis spread up to the knee, and then could be traced along the inner side of the thigh to the saphenous opening.

A consultation in the latter part of October with Dr. Clarke established the absence of pulsation in the posterior tibial and in the dorsalis pedis arteries. Pulsation in the left radial artery was smaller than in the right. The arteries throughout the body were apparently normal. There was no sclerosis.

The patient was then put to bed and was not allowed to leave it on any pretext.

Nov. 15, 1906.—Femoral artery pulsates somewhat. Pulsations can be felt in artery just internal to front of tibia. This pulsation ceases at a point half way down the leg. The patient wears stockinette bandages. The terminal joint of his left forefinger is numb and cold.

Jan. 10, 1907.—The patient has been in bed since last note. Inflammatory symptoms have disappeared. Will now go about apartment in wheeled chair.

Jan. 22.—Leg in fairly good condition; circulation fair.

Jan. 24.—Slight trace of albumin in morning urine. Albuminous food cut down.

Feb. 10.—The patient walks about

apartment to a moderate extent. The lower half of the leg and the foot are cold.

Jan. 1, 1908.—The patient remained in his apartment during the entire winter. As soon as all acute symptoms had disappeared massage was begun, and for several months was continued. It was later replaced by vibratory massage. With the advent of warmer weather he began to go about, and gradually resumed his accustomed manner of life, continuing, however, the vibratory massage. He was instructed to avoid injury and exposure to cold.

Feb. 13.—The leg is in better condition than it has ever been since first observation. Circulation is good in the toes; there is slight coldness of the foot. Pulsation can be felt as before half way down the leg, but no arterial pulsation can be felt below that point. Radials and temporals are normal. Patient says that he injured the skin on the back of his foot three months ago, but that the wound healed slowly. Vibration twice daily is being continued.

In spite of the improvement in the leg, the prognosis, if our ideas on the underlying pathologic process are correct, is very unfavorable. A wound is liable to put on the nutrition of the tissues a strain they are unable to bear, and the patient will lose this leg as he did the other.

167 West 71st St.

It Pays to Advertise—
In the Street Cars

An immaculate young man in top hat and frock coat boarded a Broadway surface car at Forty-second street. Being the only person so attired, he appeared slightly self-conscious among the shoppers and matinee goers who half-filled the car.

Directly opposite him sat a corpulent Irish washerwoman. Florid and overheated she was, and looked as if she possessed an ever ready and flexible tongue. As the young man entered she smiled; as he seated himself, carefully arranging his coat tails, she smiled excessively.

As the young man slowly raised his eyes toward the advertising cards in the upper part of the car he caught sight of the Hibernian grin and stopped. Then, with evident embarrassment, he became interested in the construction of the street-car floors.

"Shure, and ain't he purty!" came in a hoarse stage whisper from Bridget. The whisper was directed to nobody in particular. Possibly Bridget was thinking aloud. But, anyhow, the young man grew a shade pinker.

"Shure, and he's so gintle!" This time Bridget's voice had gained confidence; at least half the car heard it. "Why, the other day he took me foot in his hand—shure, and he was that gintle!" She emphasized the fact by putting her head on one side, raising her shoulders and becoming kittenish.

The young man attempted to raise his eyes, but quickly dropped them, for he seemed to be the centre of attraction. Amid the suppressed giggling of the matinee girls he appeared to be earnestly trying to determine why corrugated floors should be used on street cars. It must have been a knotty problem, for he grew pinker and pinker.

"He cut me corns, he did!" Bridget's voice had now reached its full, rich, basso proportions. This time she was talking to the whole car—the conductor, the motorman, and perhaps the car ahead.

"Shure!" she went on, as she saw the incredulous but mirthful expressions about her. "He cut me corns on that foot!" She extended her mammoth-like extremity toward the middle of the car. "And he was that gintle!"

The immaculate but scarlet young man gazed still closer at the floor. Then, as if struck by a sudden idea, he pulled out a fancy leather notebook and fell to figuring.

"Yis; pared and cut me corns beeutifully!" Bridget looked at the young

man in a motherly manner. Then, as if she had not made the matter quite clear enough, she began, "And I wish youse could all see the job!"

The excitement was becoming intense. Even the conductor was taking it in from the rear platform.

The embarrassed young man, still looking at the floor, put his notebook in his pocket. Then he reached in the inside pocket of his coat and pulled out a fair-sized card, on which large black letters were in evidence. This he fastened to the back of his coat, and walked slowly toward the rear door. The card was as follows:

The Wonderful Dr. Foot,
Corn Specialist.
Come and See Him in Herald Square.

Bridget arose and followed, and they both took the car behind.—Charles H. Fitch, in "Judge."

BUNIONS

FRANK JOHNSON, CHICAGO, ILL.

The average person believes that a bunion is an enlargement of the joints at the base of the great toe, but I think this is a mistake. There are three distinct diseases of these joints, and the symptoms and appearance of them are so similar that most persons call them bunions and let it go at that.

I have known cases where a patient had all three of these diseases of the foot at the same time, and in the same joint, and the appearance was exactly like a bunion.

Bunions, dislocated joints and enlarged joints are all due primarily to ill fitting shoes, short stockings, pressure, heat or friction. Rheumatic gout also enlarges the joints, and dislocated joints are often due to accidental injury.

A bunion is an inflammation of the bursa, situated over the metatarso phalangeal joint of the great toe. This bursa is a little subcutaneous sack, which contains just enough fluid to lubricate its walls, and it protects the bone and the joint. Constant pressure, of course, causes inflammation, with the attendant symptoms of redness, swelling, pain and heat. Pain and swelling in a true bunion generally appear at intervals of two to four days, and persist for a longer or shorter period. Each recurring attack is usually worse than the preceding one, and as the bunion enlarges naturally the pressure and irritation on its surfaces increase, and often small, hard corns are produced, which are a thickening of the epidermis.

The bunion proper is caused locally by the swelling of the flesh at the base of the great or little toe. The constant pressure of the shoe if too short, too narrow or too loose in the instep so as to cause the toes to push forward when walking, will cause a swelling and the part affected becomes red and inflamed. As the swelling increases the pores on its surface begin to close, and a hard, thick skin, studded with little hard corns about the size of a pinhead or larger, cover the bunion. These little points or grains of hard substance press down into the skin and against the nerves underneath and cause excruciating pain.

A dislocated joint is often diagnosed as a bunion, but a dislocated joint can be cured much more easily than a bunion. The wearing of a short shoe will produce a dislocation of the joint of the big toe, as at that joint it is weakest and less able to stand continued and severe pressure.

Enlarged joints also come from rheumatism and gout. However, a competent chiropodist can relieve any of these troubles, although the bunion is most difficult to cure.

The newest and best ideas on the subject are to use a pad of some soft material that will take the pressure off the bunion. Of course, it will be understood that the moment the patient comes to the chiropodist he will see that not only her shoes but her stockings are of the proper size and fit. Some chiropodists use layers of felt and others build medicated cotton up around the bunion

and cover it with court plaster to hold it in place.

In my own case, I use a rubber shield, first having made a Plaster of Paris cast of the bunion, from which I make a model and then a mould, from which the rubber shields are formed to fit the bunion cast taken. The rubber is very soft and pleasant to the foot, and besides, it has the effect of reducing swelling and inflammation more rapidly than any other thing I have ever used, as it acts as a mild poultice besides removing the pressure from the affected part. It is foolish to attempt to ameliorate the pain of a bunion one's-self, and upon the first symptoms the person should go immediately to a competent chiropodist and abide by his advice as to shoes, stockings and treatment.

The feet should be given a rest every day and a chance to get air and sunshine. When one is lying down to rest it is a good practice to undress the feet, and when lounging in one's room one may go barefooted for a short time each day with beneficial results. Especially is this recommended to those who have bunions and enlarged joints. Frequently changing the shoes and stockings will keep the feet in good condition, and I think there is no economy in one pair of shoes.

Experimenting with an Old Ingrown-Nail Remedy

LECTURE DELIVERED BEFORE THE PEDIC SOCIETY

Mr. President, Ladies and Gentlemen.

In this paper I give you the results obtained from a series of experiments involving an old method of treating an ingrown nail.

It may be that other chiropodists have known of this remedy—some may even have tried it—but never having heard of it before reading about it in "Zacharie on the Foot," I feel that in relating my experiences it may lead others to experiment and publish the results they obtain.

As the book bears date of publication 1844 and revision in 1876, it will be seen that more than thirty-two years have elapsed since Mr. Wahu, principal physician of the Military Hospital at Nice, while suffering from an ingrown nail, and after trying many ineffectual expedients, at last struck a remedy which cured him. He says:

"Finally, one day, provoked at being so disabled by a trifle, which, in spite of all my force of will, prevented my walking, I examined again for the twentieth time the seat of the disease, and was struck with the idea that if I could dry up or even tan the diseased surface, so that the ulcer might be converted into a firm surface capable of resisting the cutting action of the edge of the nail, I might obtain a complete cicatrization and consequently a cure. Running over in my mind the most energetic tanning substances, I decided on employing the perchloride of iron. I obtained some in powdered form and insinuated it as deeply as possible between the free edge of the nail and the ulcer. I felt almost immediately a moderate sensation of pain, accompanied by a feeling of constriction and a strong burning sensation. A quarter of an hour after I attempted to walk, and to my great satisfaction found I could bear my weight on my foot throughout its entire length without the least pain—a thing which I had not done before for many months. The following day I carefully examined the diseased parts and found them mummified and as hard as wood. I applied a fresh quantity of perchloride of iron, which I allowed to remain for a quarter of an hour, but I have reason to believe this application useless, as the mummification was complete by the first process. I continued to walk without the least thought of my 'ongle encarne,' and about three weeks after was able, by means of a pediluvium, to remove the hardened layer of skin, under which I found a tissue of new formation which perfectly resisted the pressure of the edge of the nail. Shortly after the whole had returned to

its normal condition, and since more than two years have passed without a return of the disorder."

The reading of the above extract made such a profound impression upon me that I reread it at least a dozen times.

I have treated ingrown nails, which after a lapse of a few months again grew down into the groove, causing a return of the old trouble, with its accompanying pain.

I have had patients who were "too nervous" to even bear the sight of a knife or chisel.

In such cases, it seemed to me, a permanent cure as described above would be a blessing.

But one hesitates trying a remedy which was the means of effecting a cure so many years ago. I reasoned if it was a success, why was it not adopted generaly by the profession?

I asked several chiropodists regarding the perchloride of iron cure, but they had never heard of it.

Finally I made up my mind to try it when the opportunity presented itself, and procured an ounce of perchloride of iron in crystal form.

One day a young German mechanic came in with an ingrown nail, the outer flap of which was covered with proud flesh. I cleansed the toe, cut out the ingrown portion of the nail, antisepticized the groove, snipped off the proud flesh and applied the actual cautery, after which I bandaged the toe with a wet dressing of liquid borowii.

Three subsequent treatments sufficed to make the toe very presentable. Despite my warning to the patient to call daily for a fresh dressing, he believed he was cured and stayed away. In about ten days his toe began to pain, and he allowed some one to put a liberal coat of iodine thereon, with the result that two large blisters formed, and he came to me again for treatment.

A wet dressing of the borowii solution removed all traces of the inflammation. Here was my opportunity to try the perchloride of iron remedy. Next day I cleaned the nail groove and dried it out thoroughly, then pounded a crystal of perchloride of iron into powder and filled the entire cavity. In a few minutes the patient complained of a burning sensation, and I noticed that the powder had melted into a gummy substance. This I left undisturbed for fifteen minutes. At the expiration of that time I was able to remove only a very small portion of the perchloride of iron, for it had hardened in the groove like adamant.

Gradually the pain abated, and the patient went away without any further dressing on the toe. Next day when he called for treatment I tried to take out some of that stone-like substance, but failed. The toe was healed, and as the patient experienced no pain whatever I felt encouraged to give the remedy a further trial.

A few days thereafter a lady suffering with two slightly ingrown nails called. She was of a nervous disposition and dreaded "cutting."

I ran an excavator under the sides of the nails, thereby loosening the edges sufficiently to allow the powder to find a resting place there. Then, after trimming the free end of the nail, I cleansed the groove with peroxide of hydrogen and a five per cent. carbolic solution, after which I forced in a piece of "spong" to dry the recess. Then filled in with the perchloride of iron powder. It turned into the gummy substance as in the previous case, but there was no "burning" sensation.

The next case I tried it on was a girl about fourteen, who a year previous suffered from a badly ingrown nail which necessitated a painful operation. She came regularly every month as a precaution. I filled the nail groove with the perchloride of iron and the next day the flap seemed hardened. At all events she has had no pain since.

Now came a case where a woman had cut out a portion of nail, but had failed to remove a sliver embedded near the

root. The toe was inflamed—so much so that the touch of an instrument caused her to jerk her foot away. So I cleansed the affected region and applied the perchloride of iron. When she came again two days later I found a pus cavity in the nail groove. This I attribute to the piece of nail in the groove, which I subsequently succeeded in removing.

There was one case, though, in which I was sorry I had used the perchloride of iron—not on account of any damage it did, but because the pain occasioned by its use brought tears to the eyes of a delicate young lady. She had a sore nail groove, caused by the sharp edge of the nail penetrating it at every step she took. This case, more so than any other, appeared to me to correspond to the case of M. Wahu, as related in the book. So instead of removing the offending portion of nail I rendered the sore groove antiseptic and applied the perchloride of iron. In a few minutes she began to suffer such pain that tears came to her eyes. I immediately started in to remove as much of the iron as I could, then spread salve over the affected part and thus eased the pain, which disappeared entirely after I applied a moist bandage of liquid borowii.

The result of my experiments lead me to believe that in cases of simple ulcer, which do not heal readily on account of some mechanical irritation, the perchloride of iron remedy is a success. The burning sensation of pain is an indication that the remedy is "taking hold." But as the pain lasts only about fifteen minutes or so it is best not to consider that, because, after all, to effect a cure is our aim, and that purpose it surely achieves.

To illustrate the power of the perchloride of iron, I placed some in the groove of my great toe, and next morning noticed that the upper leather of the shoe directly over the nail groove had been drawn together in the form of a sunburst.

I have given this remedy a fair trial, and I do not feel justified in recommending it to the profession except in cases of simple wounds, as before stated. Besides, it produces a dark brown stain, which makes a sore toe really look worse than it is.

I am sorry that I cannot report complete success. It may be that some fellow chiropodist will, in time to come, experiment along this line. And if he should come across this paper I trust it may be of such benefit as will enable him to utilize the good and avoid the unpleasant experiences of one who strove for success before him.

ALFRED JOSEPH.

PES PLANUS—REJOINDER.

Editor Pedic Items.

A man who delighted to walk up the "Great White Way" and see the handsomest women in the world became envious of their gentlemen escorts. His better half was a very homely woman, who attributed the attractiveness of the "good lookers" to dress and jewels.

Thereupon he bought her fine raiment and Tiffany jewels, and together they walked up Broadway from 23d to 42d street.

Although "dressed to kill," not a man turned around to look at her.

"See!" exclaimed the husband, "you are so homely that not a man even turns his head to look after you."

"That's because you are with me," she replied. "If I walked alone lots of men would turn to look after me." And to demonstrate she walked alone, her husband trailing half a block behind. And, sure enough, nearly every man she passed stopped and turned to look after her

For several blocks this continued, and her husband had about concluded that he had misjudged her personal appearance, when he came to an acquaintance who had also stopped to gaze.

"I wonder what's the matter with that woman?" said the acquaintance, pointing toward his wife.

"Why, what do you mean?" asked hubby.

"She's sticking out her tongue at every man she passes."

For a long time I have been endeavoring to get certain chiropodists to write for this paper. I want to learn all I can about chiropody, and realize that the experience of others is a valuable aid to that end.

Therefore, when the signed article entitled "Pes Planus and the Chiropodist" appeared in the October issue it contained half a dozen questions all calling for an answer.

In the April issue one of our fellow practitioners comments on the article in question, but in so doing makes misstatements which lead me to believe his powers of interpretation are limited.

He winds up his criticism with the hope that his remarks will not be taken as a "knock."

I know from past experience that a person who reads a paper, writes for publication or makes an address lays himself open for criticism. But when that criticism comes it must bear all the marks of honest criticism and have the stamp "Truth" conspicuously displayed.

Much criticism, whether just or unjust, makes one case-hardened. And if I have succeeded in attracting my critic's attention by "sticking out my tongue," he should at least be careful not to pervert the facts and thus place himself in a false position.

Now, I never made the statement that "fully 40 per cent. of the chiropodist's patients had fallen or weak arches" from my own observation, but accepted the view of a chiropodist longer in practice than our critical friend. This man has been for years in a locality inhabited by the working class, amongst which the condition of weak and fallen arches is quite prevalent.

When a patient complains of pains in the ankle or leg years of experience have taught this chiropodist that a brace is needed, and forthwith he provides such for his patient and himself fits it on. For this, together with the braces, he charges the modest sum of $2 or $3, knowing that the patient cannot afford to pay more.

From the tone of his article I imagine that when a case of weak or fallen arch comes to our critic's notice he forthwith refers the patient to some orthopedic surgeon for treatment.

But one must not overlook the fact that his office is located in the heart of the shopping district—that the majority of his patients belong to the wealthy class and are well able to pay the large fees as a rule demanded by orthopedic surgeons.

He further on says that he has never tried to familiarize himself with the many so-called arch supporters on the market, and believes that such contrivances are beyond the province of the chiropodist.

Now, it stands to reason if one knows little or nothing regarding the merits or demerits of an article, he is incapable of consistently recommending or even passing judgment thereon.

It seems that the author of the "Reply" believes a chiropodist should only know how to cut corns and treat ingrown nails, and if a patient with pain in the instep or on the sole of the foot consults him he should be referred directly to an orthopedic surgeon, thus exhibiting ignorance on the part of the chiropodist.

Here we disagree again. If it is incompatible for a chiropodist to tell a patient he needs arch supporters and refer him to a reliable place where such articles can be obtained, it is just as incompatible for a chiropodist to talk about the merits of shoes.

And does the doctor claim to know anything about shoes? Well, rather! On May 8, 1900, he read a paper before the Pedic Society the title of which was "Shoes: Some of the Effects on the Feet." Therein he tells all about shoes, displaying such a knowledge that one is led to believe he made it a life study.

This knowledge of shoes, and the lack of knowledge regarding braces, shows inconsistency on his part. To my mind

it is the duty of the chiropodist, as much as the orthopedist, to learn all about the foot, even to the shoes and stockings that cover it.

Near the last comes a paragraph wherein our friend makes a misstatement. He states that he has lately had patients who have been victims of the "well-meaning-but-beyond-his depth chiropodist, and the brace maker who was willing but not able."

If I am the party he refers to I will ask him to produce facts. For during my brief career as a chiropodist in active practice I have never sold a brace, nor even taken a cast of a patient's foot. But I have recommended to dozens of people the advantages of wearing braces, and referred them to the firm which manufactures them for most of the orthopedic surgeons.

Very truly yours,
ALFRED JOSEPH.

Some Advice to Beginners

"Never take chances!" said an oldtime chiropodist to a young man who had just entered the profession. "By taking chances I mean that you must not imagine you are a surgeon and treat your patients like a surgeon would his.

"I know that the desire of a beginner in chiropody is to undertake all kinds of cases—even those beyond his ken—and that's where he makes his greatest mistake. Remember, it's better to be sure than sorry.

"People go to a chiropodist's office for relief—not for a cure. And every chiropodist can and does give relief from pain. When a patient comes to your office and asks for more than relief—when he is looking for a permanent cure—it is your duty as a chiropodist and an honest man to refer him to a competent surgeon for treatment.

"When I first embarked in chiropody I thought I knew it all. Every day I treated a dozen or more persons, to all of whom I gave relief. This instilled confidence in me, and when people came and talked to me regarding a permanent cure I was quite ready to undertake the task, not hesitating to cut into the tissues or even to apply the strongest cauterizing agents.

"I could write a book, every page of which would tell of the suffering which people endured on my account. Bear in mind the antiseptic remedies and methods of the present day were not in vogue at that time.

"But one day the awakening came. I found that instead of increasing, my business was decreasing. And it did not take me long to find the reason therefor. I immediately stopped all attempts to effect a cure, and sought only to give patients the relief which they sought. In other words, I devoted my attention strictly and solely to chiropody, and the most severe cases I referred to a surgeon.

"You will have patients suffering from vascular corns who will come in every week for relief. Some day you will be tempted to effect a cure, and will perhaps apply a nitric acid. You may by that means effect a permanent cure and earn the everlasting gratitude of your patient. You may even be successful a second time. But the time will come, when instead of a cure, you have scored a miserable failure. The patient, after suffering much pain, goes to his physician, and the latter finds a very sore toe, with pus and infection.

"Of course, you will be blamed for that condition, notwithstanding you may have been successful in a score of previous cases. The same thing applies to all suppurating or infected cases.

"A great deal depends on the locality of your office. If you are in a section wherein the people are of the better class few of the severe cases will come to you for treatment. The physician is more often consulted. But in a locality inhabited by the working class the chiropodist is called on to treat every ailment of the foot. You will find that people attend to their own feet until they have perhaps brought on infection.

Then they will come to your office and expect an immediate cure.

"Such cases I advise you to send to a physician, because, in the first place, the amount of money you will receive for treating the case will not pay you to handle it, and, in the second place, the chances you are taking are too great.

"If you are compelled to treat an infected toe, demand a proper fee for your services, and insist on payment. If the patient is unwilling or unable to pay you the amount you ask, refer him to his physician or to some hospital.

"You will find that the advice I have given you is good. Study your profession and keep within its bounds. Learn all about the latest and most approved antiseptic methods and remedies. Don't criticise the work or methods of other chiropodists. On the contrary, meet them with hand extended in good fellowship and with a friendly word, and the success which comes to you will be deserved, for you will be an honor to yourself and a credit to the profession of chiropody."

Antiseptics in Chiropody

The use of antiseptics for the destruction of micro-organisms is so thoroughly established that it would be a rarity to find a chiropodist who did not employ them in his practice.

Nevertheless, a brief description, history and value of the most popular germ-destroying factors might prove of interest to the profession.

CARBOLIC ACID (C_6H_6O).

The use of carbolic acid as an antiseptic owes its introduction to Lemaire, of France, who, in 1863, was the first to realize the truth of the germ theory as applied to wounds.

Three years later Dr. Lister, of Glasgow, improved on the Lemaire discovery by various modifications, until he finally evolved a complete system of wound-dressing, based on antiseptic properties This system became famous as the Listerian method.

Still, to carbolic acid will always belong the distinction of having been the agent through which the possibilities of antiseptics in the treatment of wounds was first demonstrated.

Carbolic acid is a product of the destructive distillation of coal. Pure carbolic acid is absolute phenol. It is in the form of pinkish crystals, readily soluble in fifteen parts of water. Heat liquefies it.

A five per cent. carbolic acid solution (1-20) is employed for purifying the hands of the operator, before and after an operation; also to disinfect the field of operation and all instruments used in operating.

A two and one-half per cent. solution (1-40) is used for syringing a wound.

The properties of carbolic acid which commend it for use as an antiseptic are: (1) Its reliability. A 5 per cent. solution destroys micro-organisms in one-half minute, while a 2½ per cent. solution does the work in a minute. (2) Its diffusibility, or power to mix with nearly all other antiseptic substances, whereby complete and thorough disinfection of all parts of the wound is favored.

There are some disadvantages in the use of carbolic acid, however, as, for instance, the local irritation which it excites. When brought in contact with albuminous fluids, as serum or pus, it forms a compound with the albumen (phenol-albuminate) so that its addition in large quantities and in greater strength is necessary to secure complete disinfection of wounds already septic.

The irritation produced by using carbolic acid increases capillary oozing, and excites an excessive and prolonged flow of serum from the wound. Eczema and erthema of the skin covered by carbolic dressings is not an infrequent effect. Superficial necrosis of skin and connective tissue has frequently followed the long continued use of even weak solutions.

Its volatility lessens its usefulness as an agent to secure permanent antisepsis, thus making frequent renewals of the

dressings necessary, thereby violating one of the fundamental principles of wound treatment—that of rest.

Another disadvantage of carbolic acid is its toxic qualities. In large cavities or extensive wounds the absorption of carbolic acid in poisonous quantities is frequently observed. Some persons are peculiarly susceptible to its influence, and a small quantity will suffice to excite symptoms of poisoning. The severe cases exhibit symptoms of profound collapse, which speedily terminates in death. In the less severe cases there are gastric disturbances, as loss of appetite, nausea, increase of saliva, stupor, giddiness, noise in the head, or other signs of cerebral trouble. The secretion of urine is diminished, and often becomes a dark, olive green color. When any of these symptoms appear the use of carbolic acid should at once be stopped.

According to Dr. Cheyne, carbolic acid poisoning was a thing of rare occurrence in Lister's practice, because he seldom brought it directly in contact with a wound, but applied it freely to everything which might come in contact with a wound. He did not irrigate wounds, nor inject them, nor even wash away the blood and dirt from the line of incision.

The importance of the disadvantages that attend the use of carbolic acid in the treatment of wounds is so great that its use has become very much circumscribed. As an antiseptic bath for the immersion of metallic instruments it stands pre-eminent. Chiropodists would do well to familiarize themselves with the code of antiseptic rules and formulas recently issued by the Pedic Society.

CORROSIVE SUBLIMATE ($HgCl_2$).

The use of bi-chloride of mercury in the treatment of wounds dates from the publication, in 1881, of the researches of Koch upon "Disinfection."

The anti-putrefactive properties of this salt had long been a matter of common knowledge, but surgeons feared to use it because of its toxic effect through absorption.

The observations of Koch, however, inspired surgeons to use corrosive sublimate in solutions of 1-1000 to 1-1500 as a germicide, and the results were most satisfactory. The healing of wounds after disinfection by the sublimate, and under dressings impregnated with it, was accomplished with a certainty previously unknown.

Wound surfaces flushed by it were not provoked to profuse serous discharges, nor did increased capillary oozing follow its application. It was free from odor.

In some persons, however, the ordinary solutions irritated the skin, and in some cases a skin inflammation was provoked.

Corrosive sublimate is a very reliable agent for the disinfection of fresh wounds that are known to be infected For this purpose 1-5000 aqueous solutions are used.

For disinfecting the skin in regions that are to be operated upon, and for disinfecting the hands of the operator, a 1-2000 solution is used.

As a styptic, the application for about 10 minutes of a 1-1000 bi-chloride of mercury solution is very effective, besides rendering the wound aseptic.

SALICYLIC ACID—($C_7H_6O_3$)

By the action of carbolic acid on phenol sodium, sodium salicylate is produced; and by the decomposition of the latter by hydrochloric acid, the free salicylic acid is secured—an odorless, nearly tasteless, unirritating, comparatively insoluble, non-poisonous agent, with marked antiseptic properties.

Its use as an antiseptic was advocated by Thiersch of Liepzig, who used it both as a powder and in solution. Its combination with boracic acid in solution has since generally been known as "Thiersch's Solution," which contains 3 parts of salicylic acid and 30 parts of boracic acid to 1,000 parts of water.

Wound surfaces are not irritated by it, nor is the granulating process disturbed.

As a germicide, its powers are feeble, although in the aseptic technique of the present day, it still finds a place as a preliminary application to the skin of a region to be disinfected, because of the property of the acid to soften epidermal scales, and thus render more easy and certain their thorough removal by later scrubbings and the deeper penetration of a more efficient bactericide.

Salicylic acid is much used in the preparation of the so-called "corn cures," on account of its power of disintegrating the epidermis from the derma. A 10 per cent salicylic ointment placed in calloused nail grooves will in a few days restore the nail grooves to their normal condition.

BORACIC ACID—(H_3BO_3)

A saturated solution of boracic acid has no bactericidal property and but feeble inhibiting power. It is, however, unirritating and non-toxic, and may be used in the dressing of extensive burns, or as an ingredient of a protective ointment to be applied to a granulating surface.

IODINE

The antiseptic properties of iodine, according to Sternberg's experiments, are many fold greater than those of carbolic acid—as a bactericide five times, and as a restrainer of bacterial growth eight times as great—but they have attracted general attention only since the introduction, as an antiseptic, of its compound —iodoform, the teriodide of formyl (CHI_3), which contains 96 per cent of iodine

The advantages possessed by iodoform caused its immediate and extensive adoption. It introduced a new method of antiseptic dressing, the *dry-powder* dressing, which more perfectly met the requirements of a wound-dressing than any other method that had preceded it. It restrained wound-secretion, and thus diminished the amount of food for bacterial growth. It did not irritate, and its evaporating qualities were so slow that the frequency of the dressings required were greatly lessened.

The odor and the toxic qualities of the drug were at first the chief disadvantages that seemed to limit its use.

Its odor is pervasive and lasting, and disagreeable to most people. Its toxic qualities are such as to require caution in using it, if risks of fatal consequences are to be avoided. It acts by absorption into the general circulation of poisonous quantities from wound surfaces.

Old persons are especially liable to suffer from iodoform poisoning. It should be employed with caution, and in such a manner that it can be easily removed from a wound in case symptoms of poisoning should appear.

It is well known that pyogenic organisms can preserve their vitality after being kept for many days covered by iodoform, and that the latter could even be the means of conveying infection.

Although iodoform has the power to inhibit the growth of some organisms, it has but feeble power over the staphylococci and streptococci of suppuration—the kind chiropodists deal with in cases of infected toes.

Nevertheless, its clinical value to prevent suppuration and to minify septic disturbances in wounds is unquestionable. The theory that the value of iodoform rested in a power to neutralize the products of bacterial growth, and thus to eliminate from an infected wound the chief agent that rendered possible the continued activity of bacterial life, was confirmed by the work of Behring, who proved that in the presence of pus a chemical reaction occurred between the ptomaines and the iodoform, whereby the iodoform was decomposed, iodine set free, and the ptomaines themselves destroyed.

The final outcome of the study of the properties of iodoform has been thus to greatly restrict its use, but nevertheless to establish it as an antiseptic agent of

the greatest value in wounds in which an active bacterial growth was present or unavoidable, as in all extensive open wounds, in wounds involving mucous membranes, and in wounds communicating with septic cavities, as in abscesses.

Iodoform diminishes secretion, decomposes ptomaines and stimulates leucocytosis, and, when itself is decomposed, liberates the germicidal iodine. It possesses but little germicidal power in itself, and should therefore always be sterilized by an immersion in a solution of bi-chloride of mercury or by exposure to heat before being used as a surgical dressing.

The antiseptic properties of the compounds of iodine, having the advantage of iodoform without its disagreeable odor and its toxic qualities, are as follows:

ARISTOL—(DI-THYMOL IODIDE)

A compound containing about 46 per cent of iodine, formed by the reaction between thymol and iodine and iodide of potassium in the presence of sodium hydrate. It is a pale, chocolate colored, non-crystallized powder, insoluble in water, slightly soluble in alcohol, readily soluble in ether.

AIROL — (OXYIODIDE OF BISMUTH SUBGALLATE)

A compound formed from basic bismuth gallate by substituting an atom of iodine for one hydroxyl group. It is a light greenish gray, fine, inodorous and tasteless powder.

IODOL — (TETRA-IODO-PYRROL)

A compound containing 89 per cent of iodine, formed by reaction between iodine and pyrol in the presence of alcohol. It is yellow, inodorous, tasteless powder, insoluble in water, but freely soluble in alcohol.

NOSOPHEN—(TETRA-IODO-PHENOL-PHTALEIN)

A compound containing 60 per cent of iodine. It is obtained by the reaction of iodine on a solution of phenol-phtalein. It forms a pale, grayish, inodorous and tasteless powder, which is fine and light, insoluble in water and alcohol, and can be exposed to heat up to 225 degrees C. without injury.

Aristol, airol, iodol and nosophen have valuaable properties to restrain the growth of germs, lessen serous exudations and stimulate cell activity in the surfaces with which they are brought in contact. They can be used to advantage by chiropodists in many of the cases they are called upon to treat.

ZINC OXIDE.

Zinc oxide is especially worthy of commendation as a dusting powder in treating burns and abrasions, and for use upon the skin about a wound. It restrains the activity of the epidermal organisms. It is unirritating, and with serous secretions forms a bland and soft magma. It is odorless and non-toxic. A mixture of equal parts of zinc oxide and of water, with the addition of 10 per cent of zinc chloride, forms a paste which, when applied to skin wounds, rapidly dries into a firm protective crust or artificial scab. This is the zinc paste dressing of Socin.

OTHER ANTISEPTIC AGENTS

There are so many agents possessing the power of destroying micro-organisms that too much space would be occupied in describing them. Among these are Bismuth Subnitrate, Bismuth Subgallate, Zinc Chloride, Zinc Sulphocarbolate, Aluminium Acetate (Liq. Borowii), Acetanilid, Peroxide of Hydrogen, Mercuric Iodate, Naphthalin, Beta-Naphthol, Pyoktanin, Formic Aldehyde, Formaldehyde Gas and Heat.

HEAT

The temperature of boiling water, 212 degrees Fahr., is sufficient to quickly destroy all known pathogenic bacteria. None of the ordinary pus-forming germs are spore bearers, so that their destruc-

tion, in dressings, instruments and materials used in wound treatment, is simple and rapid.

A much higher temperature is required to destroy germs by means of dry heat.

The use of heat in the shape of boiling water or of steam, for the absolute and certain destruction of bacteria, is much in vogue, being preferable to chemicals for the disinfection of instruments, dressings, etc., used in the treatment of wounds.

The subject matter of this article was taken from the work of Dr. L. S. Pilcher, entitled "The Treatment of Wounds," and arranged for the benefit of the readers of "The Pedic Items."

WORKING FOR THE TIP

A chiropodist who passed the Pedic examination less than a year ago, obtained a position in one of the Turkish baths. His salary was $15.00 a week. What he has to say regarding the prices charged for good work shows the lack of business ability on the part of the proprietors, and also demonstrates why it is almost impossible for other chiropodists to charge fees commensurate with their work.

"When I was taken on," he says, "the proprietor told me that for ordinary corns on both feet, the charge was fifty cents to bathers. For ingrown nails or other cases I was to use my judgment and charge about a dollar.

"One of the first cases I attended was an ingrown nail with a large chunk of proud flesh at the side. After I had finished treatment the patient inquired the charge and I told him three dollars, which he promptly paid, well satisfied with both the work and the price.

"Several other chiropodists are employed in that establishment, and I noticed that they exchanged glances. As soon as one of them was at leisure, he came over to me and said that I had done wrong in charging so much for the work, pointing out that while the patient had paid the fee demanded, I was really the loser, for he had neglected to give me a 'tip.'

"Within the next few days I saw my fellow chiropodists operating on cases for which they charged fifty cents, which in truth were cheap at two dollars.

"And the patients, too, knew that they were getting 'bargain' prices, for they invariably bestowed a tip (sometimes a quarter of a dollar, sometimes a half a dollar) on the chiropodist.

"I am in chiropody for what I can make, and I want to make all I can; but when I have to resort to 'cheating the boss,' besides humbling the dignity of the profession, I feel that it is time to quit. I simply refuse to lower myself to the level of working for a 'tip.' I do the best I can in every case, and if the patient desires to reward my efforts, I cheerfully thank him. But that I should treat a foot for fifty cents that is worth at least one dollar, simply to obtain a tip—well, I draw the line at that.

"Now let us see the effect of the low fee on the patient. He does not know the value of good chiropody. All he knows is that he paid fifty cents at the Turkish bath to have his corns removed, or his ingrown nail treated, and concludes that to be the prevailing price. At some future time, when his feet trouble him, he drops into the office of some reliable chiropodist who has for years been endeavoring to contribute his share toward elevating the standard of chiropody. The practitioner gives his patient the sought for relief and charges what he considers the value of his services—say, two dollars.

"Then the patient complains at the price and, despite the relief he obtained, goes away with a 'grouch,' imagining that he has been overcharged.

"This condition of affairs, it seems to me, is all wrong. After a man has qualified and obtained his license to practise chiropody, he should be above such a thing as a tip. Such procedure might have been proper before he became a

chiropodist, when perhaps he pursued his vocation of barber, masseur, printer, butcher, baker or candlestick maker. But now he is a professional man, and, as such, his duty is to elevate, not degrade, his profession. Who ever heard of a doctor or a dentist or a veterinary working for a tip? If a chiropodist has to work for $15.00 a week, it is probably because his services are not worth more.

"The remedy of the tipping evil rests with the proprietors themselves. They should instruct their employes to charge a fair price for chiropody, instead of one uniform fee for anything. Then in place of paying $15.00 a week to their chiropodists, they will be enabled to give them a salary suitable to their requirements as professional men, make vastly more money for themselves, and contribute their quota toward the elevation of the profession of chiropody."

CORNS BEFORE A STORM

No doubt you have observed that when a storm is approaching, and the atmospheric pressure is heavy, many people are forced to call on the chiropodist.

You have often listened to the patient in your chair predict the approach of a storm by the pain in his corns.

Now tell me what causes that pain. For years I was under the impression that everybody knew. In fact, I was ashamed of my ignorance regarding that question.

One day I screwed up courage to ask a chiropodist whom I knew to be well posted. To my surprise he was as much puzzled as I was.

Then I tried another chiropodist, but his answer was a mere guess.

Once again did I propound the question: "What causes the pain around a corn when a storm is approaching?" And another chiropodist essayed a guess.

Then I tried the medical profession. I asked several doctors, but each gave a different answer, none of which satisfied me, because no two were alike.

I next attempted to find my answer in some of the medical works, but not even a passing reference was my reward.

Now it's funny how a little problem like that will bob up and absorb one's attention. For years I had been getting along nicely in ignorance of what caused the pain around a corn on the approach of a storm; and no doubt I could have attended just as well as before to my duties, but ever and anon that confounded problem would come to my mind, and set me thinking. If there were any pecuniary benefit to me in its solution, the effort might be worth the while.

One day, after I had exhausted all my efforts to find an answer, I sat down and wrote the following query to six of the most prominent medical men in New York:

"Dear Sir: Will you please tell me why people afflicted with rheumatism, fractures, corns, etc., suffer pain before a storm comes on? Very truly yours," etc.

I enclosed self-addressed envelopes, and four of the six replied.

Number one, an author of a standard medical work, wrote:

"Dr. ——— regrets very much that he is unable to answer your question."

Number two, a man with an international reputation, wrote:

"In reply to your inquiry I beg to say that while your question is apparently simple, it becomes complicated on a more thorough contemplation. I am going to write a book on part of the subject, and will let you know when it is published."

Number three, a famous orthopedic surgeon, gave the following reply:

"Change in atmospheric pressure, which influences the circulation in the sensitive parts, is the usual explanation."

Number four, a young surgeon rapidly forging to the front, sent the following:

"I believe that the accepted explanation of the phenomena you mention is that the sudden change in barometric

pressure is associated with a change in blood pressure which is accompanied by a dilatation of the capillaries, with consequent tension and pain from this source."

To be frank, none of these answers satisfied me, and I kept seeking for more information from physicians. But, alas! all I received was mere guesswork. Some were theories as, for instance:

"The skin absorbs the moisture in the air, the same as a barometer." As the contents of a barometer is sealed in an airtight glass tube, it is impossible for any moisture to penetrate.

At the February meeting of the Pedic Society, I propounded the question in the hope that some one present would offer a theory, and gave full details of the progressive steps I took. But no one replied.

I now put it up to the readers of this paper, and in so doing will offer a theory of my own.

Those of you who have been summering at the seashore may have noticed that when a storm was approaching, common table salt would clog in its receptacle, The day may have been perfect, no indication of a storm being evident. Yet the "caking" of that salt showed that a storm was approaching.

Now the blood contains certain salts. In inflammatory processes these salts, together with the plasma and corpuscles, escape from the vessels into the tissues, and accumulate about parts where the blood circulation is interrupted, as around corns, fractures, rheumatism, etc.

If the atmospheric pressure affects salt to such a degree as will cause it to "cake," it might be reasoned that such a lump, however small, would press on a nerve and cause those annoying twinges.

From people afflicted with those disorders, I learn that the pains are never steady, but rather of a "shooting" kind.

ALFRED JOSEPH.

FOR SALE

An Old Established Chiropodist's Office. Best Location in Brooklyn. Good reasons for selling. Apply to Anthony Interrante, 482 Fulton Street, Brooklyn, N. Y.

An Unusual Case of Joint Infection

BY LEONARD W. ELY, M. D.,
Orthopedic Surgeon to the Metropolitan Hospital, etc., New York

Through the courtesy of my friend, R. P. Jantzen, of this city, it has recently been my privilege to see a case of joint infection that presented an appearance quite out of the ordinary. In fact so peculiar were the symptoms and physical signs that I hesitate to make a positive diagnosis as to the exact type of infection.

The patient, E. H., about 50 years old, married, with a negative previous history, presented herself at my office on June 18th, and gave the following history:

For the past six or seven years she had suffered pain in the metatarso-phalangeal joint of the left great toe. This pain came more or less in attacks. Sometimes it would disappear almost entirely. It was unaccompanied by sensitiveness to pressure. No history of injury could be elicited, and no other joints were involved. The patient had been treated in various ways, and had worn all sorts of shoes.

Examination revealed in the first place two very weak, flat feet. The metatarso-phalangeal joint of the left great toe was thickened and changed in contour. Motion in it was limited and painful. No sensitiveness to external pressure could be elicited. The patient herself was well nourished and presented no signs of rheumatism or of gout.

The X-ray showed a very interesting condition present. The joint line was almost entirely obliterated, and the phalanx was subluxated inward. Various processes had been thrown out about the ends of the two bones. The whole appearance of the skiagram was that of a low grade type of chronic inflammation.

The treatment consisted of: 1. Massage and passive motion to limber up the stiffened toe. 2. Flat-foot braces to ease

the feet, which had also occasioned the patient considerable pain. 3. Properly constructed shoes. 4. Operation was also advised, but the patient would not consent to this at present. Probable excision of the diseased joint is the only thing that will give permanent relief.

ACUTE ABSCESSES

Their Symptoms and Treatment

BY ALFRED JOSEPH

All suppurative processes are due to pyogenic infection.

Some chemical irritants, such as croton oil, turpentine and nitrate of silver are capable of producing pus. This fluid, however, is non-infectious, does not contain pyogenic micro-organisms, and has none of the ordinary properties of pus.

Sources of Infection.—There are two sources of pyogenic infection; an external and an internal. Infection can and does occur through the glands of the skin. By this means pustules, boils and carbuncles are produced. External infection is also of frequent occurrence through scratches, abrasions and wounds.

Internal infections occur through the blood and lymph channels. The blood of persons who are in a debilitated condition frequently contains one or more pyogenic organisms. In such persons acute suppurative osteomyelitis may follow a slight injury to a bone, or suppuration may occur after a simple fracture, or suppuration may take place in a subcutaneous blood clot, and carried through the circulation to small, terminal vessels, and there arrested and subsequently surrounded by an infected thrombus, resulting in abscesses.

The Formation of Acute Abscesses.—When pyogenic organisms get into the tissues, they multiply and produce toxins which are diffused into the surrounding tissues, setting up an inflammatory action. The blood vessels dilate and the blood current becomes more vapid. This condition is followed by a slowing of the current, with an escape of the blood plasma and leucocytes into the surrounding tissues. The toxins now act more vigorously upon the injured cells, destroying their vitality, and resulting in dead tissue. This contains many bacteria and is surrounded by an area of inflammation in which there are a great number of leucocytes. The latter are attracted to the inflamed area by the products of bacterial growth. The dead tissue finally separates from the living tissue by the peptonizing action of the toxins and by the digestive action of the leucocytes. The dead tissue is surrounded by a fluid, the liquor puris, which is the changed blood serum, and which contains the pus cells, the former leucocytes. An abscess may now be said to have formed.

During the formation of an abscess the connective tissue cells proliferate, and, with the leucocytes and new-formed capillaries, they build a wall of granulation tissue around the abscess cavity. This is a protective process brought about by the cellular elements for the purpose of limiting the spread of the abscess.

When the toxins are very virulent or the vitality of the tissues reduced, the wall of granulation tissue will not be produced, or will be imperfectly formed, or, if formed, it may be destroyed by the virulent toxins; in either event the abscess will continue to extend, and finally points and bursts, discharging its contents.

With the escape of the pus and toxins the cavity of the abscess rapidly diminishes in size. This diminution is caused by the formation of layers of granulation tissue internally, while the outer layers are converted into fibrous tissue, which contracts and diminishes the size of the abscess cavity.

In some cases, with the formation of a wall of granulation tissue, the leucocytes and blood plasma are able to de-

stroy the bacteria in the abscess, and the growth ceases. In these, the liquid portion of the abscess is absorbed, the leucocytes undergo degeneration, while the abscess cavity is obliterated by the formation of granulation tissue within and the contraction of fibrous tissue without.

SYMPTOMS.—The local symptoms of a subcutaneous abscess are those of infection. There is redness, heat, pain, swelling and disturbances of function. The parts at first are hard and brawny, but as the pus is formed and approaches the surface, the center of the inflamed area becomes soft and fluctulant, and later the abscess breaks. If the drainage is good, the symptoms gradually or suddenly subside. The rim of hard tissue which surround the soft, fluctuant center is gradually broken up and absorbed. After the abscess cavity is obliterated by the formation of granular tissue and the contraction of the new connective tissue, all that remains is new connective, or scar tissue.

The subjective symptoms are pain, often throbbing in character, fever, and frequently a chill; there is usually insomnia, loss of appetite and gastro-intestinal disturbances.

TREATMENT.—Suppuration can sometimes be aborted by rest and by the application of ice or antiseptic lotions. Ordinarily, however, the process cannot be prevented, and the application of poultices resorted to.

When the pus has formed, or even before, a free incision should be made in the inflamed area for the purpose of giving vent to the pus and affording drainage, or for the purpose of relieving tension. It is necessary, in order to insure a speedy recovery, that a free incision should be made and good drainage established.

If the abscess cavity does not readily diminish in size, and the flow of pus in a few days practically cease, it is probable that there are pockets of pus which are not being well drained. In this case, the pus cavity should be explored with a sound, and these pockets opened and drained.

Chiropodists frequently come in contact with inflammatory cases where there is probable pus beneath the tissues. If rest, ice applications or antiseptic lotions do not restore the parts to their condition, Dr. A. Hamilton Levings, Professor of Surgery in the Wisconsin College, recommends making a free incision through the skin over the center of the inflamed area, and then locating the pus by inserting a pair of pointed but closed artery forceps in the direction of the suspected pus. If pus is not encountered, the forceps should be withdrawn and then thrust into the tissues in a different direction.

Having once located the pus, the blades of the forceps while within the cavity of the abscess are opened as wide as possible, and withdrawn while in this position, so as to tear a considerable opening into the wall of the abscess, and into the tissue, through which a drainage tube may be passed.

The advantage of this method in certain inflamed areas over incision is that one is not likely by it to do injury to important structures. There is great risk in making a deep incision into an inflamed area surrounded by important structures, because the lips of the wound cannot be retracted nor the anatomical structures of the part recognized.

In the opening, as well as in the subsequent treatment of acute abscesses, strict antiseptic precautions should be carried out, otherwise mixed infection may occur, and the healing process be greatly delayed.

In June of this year, I had a patient with an acute abscess—the result of a suppurating soft corn between the fourth and fifth toes. When the patient first came to my office, the last two digits were so swollen and red that I was unable to pull them apart, in order to obtain a view of what might be between. The outer side of the dorsum of the foot

was swollen from the phalanges to the ankle, and as red as a beet.

A wet dressing of liquid borowii, covered with a gutta percha protective, failed to show any improvement at the end of twenty-four hours. Then advised bichloride of mercury applications, 1 in 400. Still no improvement.

That night, at the meeting of the Pedic Society, I described the case to Dr. Elliott W. Johnson, and asked him whether or not poultices should be applied. He advised rubbing the inflamed parts for fifteen minutes with Petrogen of Iodine, thereby permitting it to penetrate into the swollen tissues. Then syringe between the toes with peroxide of hydrogen. After which apply poultices of flaxseed and slippery elm powder.

Next morning I visited the patient and followed the directions of Dr. Johnson to the letter. Thursday morning a noticeable improvement manifested itself. The abscess came to a point, burst, and a considerable quantity of pus flowed out. Friday morning found the foot almost normal, and the next day the patient could use his foot as well as ever.

I have mentioned this case and the treatment I pursued in order that chiropodists in general may avail themselves of its benefits should a similar case come to their notice. There were no incisions made, nor resort to surgery had. The entire treatment was of a therapeutic nature, and therefore very applicable to chiropodists.

The Christmas, 1908, number will be a masterpiece, so send along your ads.

The Next Examination.

The Board of Examiners desire to announce that the next examination will be held at the Society's meeting rooms on October 27, 1908, at 8 P. M. Applications must be filed not later than October 22, 1908.

MAUGER & SCHUSTER

Manufacturers of

Orthopedic Appliances

The Prof. Royal Whitman's Brace for Flat Feet and Weak Arches, constructed from Specially Made Plaster Molds of the Feet

201 East 52d Street

Near Third Avenue

NEW YORK

Telephone 2471 Plaza

DR. FRANK JOHNSON

Chiropodist

126 State Street, Chicago, Ill.

Bunion Shields a Specialty. Chiropodists increase your business as Agents for Bunion Shields. Write to-day.

RUDOLPH HEROLD

328-330 Seventh Avenue

Bet. 28th and 29th Streets

Expert Manufacturer of Chiropodists' Instruments Honing and Grinding

Dr. Alfred Joseph **CHIROPODIST**

335 Willis Avenue

PREPARES STUDENTS TO PASS THE PEDIC EXAMINATIONS

REFERENCES FURNISHED